An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Child and Adolescent Inpatient Psychiatric and Residential Treatment Center Services

Summary and Analysis of Public Comments and Staff Recommendation

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December 20, 2001

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I. Introduction

The working paper entitled *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Child and Adolescent Inpatient Psychiatric and RTC Services*, was developed by staff to the Maryland Health Care Commission ("MHCC" or the "Commission") as one in a series of working papers that the MHCC has released during Phase II of its two-year study examining specific issues and implications for change to the Certificate of Need ("CON") model of health care regulation. The study was required by House Bill 995 (1999). The working paper provided the basis for public comments on whether changes are needed with respect to CON regulation of child and adolescent inpatient psychiatric and Residential Treatment Center ("RTC") services in Maryland. The current CON program considers the availability, accessibility, cost, and quality of care in regulating these services.

The working paper presented several potential alternative regulatory strategies for addressing the above characteristics. The options are as follows:

Option 1: Maintain Existing Certificate of Need Review Program Regulation for Child and Adolescent Inpatient Psychiatric Beds and RTC Beds, with Commission-Mandated Data Collection for RTC Beds

Option 2: Expand Certificate of Need Program Regulation

Option 3: Partial Deregulation of Child and Adolescent Inpatient Psychiatric Services and RTC Services

A. Maintain Regulation of Child/Adolescent Hospital Facilities, But Deregulate Planning for RTCs to the Subcabinet
B. Deregulate from Certificate of Need Review Child/Adolescent Hospital Facilities and Maintain Regulation and Planning for RTCs [With] the Commission

Option 4: Deregulation of Inpatient Child and Adolescent Psychiatric Facilities from CON Review with Responsibility for Monitoring Transferred to the Mental Hygiene Administration/the Subcabinet or the Office for Children, Youth, and Families

Option 5: Deregulate Child and Adolescent Psychiatric Services from Certificate of Need Review; Create Data Reporting Model to Encourage Quality of Care

A. Consumer-Oriented Specific Public Report Card for Child and Adolescent Inpatient Psychiatric Services
B. Provider Feedback Performance Reports

Option 6: Deregulation of Child and Adolescent Inpatient Psychiatric Services and Residential Treatment Centers from Certificate of Need Review

The Commission released the working paper on October 18, 2001, and invited interested organizations and individuals to submit written comments on this paper through the close of business, Monday, November 19, 2001. The Commission received written comments from the following six organizations:

- Villa Maria
- Woodbourne
- Maryland Disability Law Center
- Howard County Board of Health
- Mental Hygiene Administration
- The Governor's Office for Children, Youth, and Families

The public comments are summarized in Part II of this document. Staff analysis of the public comments is provided in Part III. A staff recommendation is provided in Part IV. **Public comment on this document, and on Staff's proposed recommendation, is due to the Commission by January 3, 2002.**

II. Summary of Public Comments[1]

In his response to the Commission's working paper on child and adolescent inpatient psychiatric and RTC services, **Villa Maria's** Administrator, Mark Greenberg, limited his comments to the analysis of RTC services and did not address those sections of the paper dealing with hospital psychiatric services for children and adolescents. Mr. Greenberg underscored the need to continue the trend toward community-based diversion and step-down options in place of institutionalization, to improve the availability of less restrictive services and make the best use of limited resources. Activities that would further these goals include the following:

- an in-state diversion program;
- case management for acutely mentally ill children and adolescents;
- expansion of therapeutic group homes and therapeutic foster care placements;
- expansion, by local management boards, of alternative levels of care;
- increases in the availability of Intensity 5 non-public school placements [for those children and adolescents who are serious emotionally disturbed]
- the availability of one-on-one behavioral aides for children who require RTC level of care, and
- improved Medicaid funding for discharge planning for RTC residents.

[1] See Appendix 1 for a complete set of the written copies received on the Child and Adolescent Inpatient Psychiatric and RTC Services Working Paper

Mr. Greenberg noted that, as of September 26, 2001, there were an "unprecedented" 89 available RTC beds in Maryland. Mr. Greenberg goes on to say that such census declines, coupled with the small sizes of RTCs and "the stringent reimbursement methodology under which [RTCs] operate, make these providers especially vulnerable" to higher costs. Consequently, Mr. Greenberg believes, "CON is more important than ever to the financial survival of existing RTC providers, and ensuring that they have adequate resources to provide high quality care." Accordingly, Villa Maria supports Options 1, 2, and 3B, and believes that since the Maryland Health Care Commission ("MHCC") is uniquely placed to draw on the expertise of other state agencies, "regulatory oversight of RTCs should remain with the MHCC, and should not be transferred to the Mental Hygiene Administration or to the Subcabinet."

While Mr. Greenberg's comments support Option 1, which includes Commission-mandated data collection, he also recognizes the need for data in these services, and notes that, "the Subcabinet recently allocated $250,000 for the creation of a comprehensive database regarding RTCs and the population they serve. This effort should go far in correcting the dearth of data in this area noted by Staff in the working paper, and will also enhance MHCC's ability to carry out meaningful health planning for RTCs."

Comments submitted on behalf of **Woodbourne** by its President and Chief Executive Officer Stanley E. Weinstein, Ph.D., also support the options that continue the regulatory oversight of RTC beds by the MHCC, Options 1, 2, and 3B. In addition, Dr. Weinstein agrees that there is a shortage of child and adolescent psychiatrists, but he also points out that "the majority of such mental health services are provided by non-psychiatrists (primarily Master Degree Social Workers)," who are also in short supply. Dr. Weinstein also noted, "The problem may be a shortage, or it could be a distribution problem in various parts of the state." Dr. Weinstein also commented about the serious problems with basic data collection for these services. He noted that Requests for Proposal ("RFPs") to be released by the Subcabinet for a comprehensive needs assessment and the resource development directory are not yet ready. In addition, Dr. Weinstein notes that while the working paper provides child and adolescent psychiatric utilization data, it does not include state hospital data. Dr. Weinstein further notes that, while the working paper noted the closure of some outpatient mental health clinics with the advent of the Public Mental Health System, he believes that there were additional programs that closed, even before newly structured system began operation. These closures created "a major void in the state's continuum of care." In conclusion, Dr. Weinstein believes that "providers, the [S]tate, and core service agencies need to review [the mental health service] delivery system [in terms of] necessary services, quality, human resources, and financial risk." In Dr. Weinstein's view, "the current system does not appear to be working."

Writing on behalf of the **Maryland Disability Law Center ("MDLC")**, Cathy S. Surace, Managing Attorney, supports the containment of the number of RTC beds and the expansion of community-based resources. Ms. Surace also advocates for changes in the RTC placement process and other innovative Medicaid system changes that would allow for the provision of RTC care in a more timely fashion to child and adolescent Medicaid recipients. MDLC "supports Option 1 in the [CON] working paper, and opposes any elimination of the Certificate of Need requirement for inpatient psychiatric care or RTC services. While [MDLC] agrees that there needs to be expanded data collection with regard to RTC care, [MDLC]

expresses no opinion at this time on the best method of data collection or whether the data should be mandated by MHCC or by another state agency." [MDLC] "agrees, however, that without such data, it is virtually impossible for the Commission to accurately determine RTC bed need for the [S]tate."

Ms. Surace agrees with Mr. Greenberg that a part of the reason behind the demand for RTC care in Maryland is that the costs for foster care and group home care, both less restrictive and less expensive examples of community-based care for mentally ill children and adolescents, are not currently reimbursed by Medicaid. MDLC has been working with Medicaid to develop Medicaid State Plan amendments so that Medicaid could bill the federal government for therapeutic costs not related to room and board costs that are not reimbursable. Additionally, Ms. Surace notes that MDLC, with its focus on the least restrictive residential care, has been working with Maryland's Medicaid Program over the past year and a half to secure the service of one-on-one therapeutic aides in the home as a more acceptable option over that of a hospital or RTC bed for a mentally ill child or adolescent.

Ms. Surace concludes that these improvements to the Medicaid system "are needed for the [S]tate to address delays in the RTC placement process. While [MDLC] acknowledges that many children have not received the psychiatric care to which they are entitled under Medicaid, there must be a multi-faceted solution and not one that focuses solely on increased hospital and RTC bed capacity. The basis for MDLC's support for CON in RTC services is its belief that "increased bed capacity will lead only to increased demand for institutional care and fewer resources available to serve children in community-based settings."

Ann Mech, R.N., J.D., Chairperson, **Howard County Board of Health,** wrote to the Commission on behalf of the Board of Health in support of Option 1: Maintain Existing Certificate of Need Program Regulation.

Oscar Morgan, Director of the State's, **Mental Hygiene Administration ("MHA")**, part of the Department of Health and Mental Hygiene, wrote to the Commission in support of Option 1, continuing regulation for all three of the services under discussion.

In his comments, Mr. Morgan took issue with some statements made in the working paper. First, Mr. Morgan makes factual corrections to two tables in the report. On page 4 of the working paper, Table 1 incorrectly listed Springfield Hospital Center as having 18 beds for children and adolescents. These beds are located at Crownsville Hospital Center in Anne Arundel County; Springfield Hospital Center does not have a child and adolescent unit. Additionally, Mr. Morgan points out that on pages 5-6 of the working paper the paragraph before Table 3 states there are 765 RTC beds and references Table 3. However Table 3 shows only 748 beds. The 748 beds represent those currently in service, and did not reflect the proposed transfer of 17 RTC beds from Rose Hill RTC to Sheppard Pratt's Berkeley and Eleanor Mann RTC that was approved by the Commission on November 15, 2001. With the Commission's approval of the transfer of these beds to the Sheppard Pratt RTC, where that facility will devote half its bed capacity to 'Lisa L' and half to a generic population, the total number of Maryland's licensed RTC beds will be 765. However, as the transferred beds have not yet been licensed at Sheppard Pratt, as of this writing, there are still 748 licensed RTC beds in operation.

Second, Mr. Morgan disagreed with the working paper's assertion that increased child and adolescent admissions to psychiatric hospitals are attributable to increasing referrals from emergency rooms and Department of Juvenile Justice facilities, and the closure of private psychiatric hospitals and day treatment programs. He especially questioned the characterization of the utilization review decisions of MHA's Administrative Service Organization ("ASO") and contractor Maryland Health Partners as "increasingly restricted." Additionally, Mr. Morgan objected to the working paper's linking of what it termed the "stringent utilization criteria" of Maryland Health Partners with MHP's capitation rates, resulting in shorter stays and higher recidivism rates for mentally ill children and adolescents in inpatient hospitals.

Third, Mr. Morgan questions the working paper's assertion that outpatient treatment centers closed due to lack of profitability, and that the perceived lack of profitability was based on State reimbursement policies. Instead, he explains some closures by the State's conversion in 1998 from a grant system to a fee-for-service system. He notes that "such a change required providers to acquire certain business acumen, including learning how to bill the State or insurers, and bill consumers for co-pays when appropriate. Some providers did not adapt accordingly." To assist some clinics to become more fiscally efficient, and still maintain quality care, the MHA has retained a consultant to study the clinics' fiscal operations. Mr. Morgan concludes this point by asking that the working paper reflect that providers in the system were the source of the conclusion reported by staff, that a causal link exists between the public system's stringent utilization review and falling admissions, lower lengths of stay, and higher recidivism by State patients.

Fourth, Mr. Morgan also takes issue with the working paper's assertion that information from Maryland Health Partners is not readily available. Mr. Morgan goes on to state "MHA has a relationship with the Maryland RTC Coalition and [has] been able to get information that provides a complete picture of RTC utilization." However, he writes that "MHA recognizes a need for a comprehensive data bank and bed registry for RTCs, including [the] types of beds [that] are available on any [given] day, to permit easier [access] by providers."

Fifth, Mr. Morgan questions the use of "anecdotal evidence that children and adolescents are not receiving the appropriate inpatient services as evidenced by long stays in hospital emergency rooms…"Mr. Morgan calls for this anecdotal evidence to be supported by documentation, because there could be a host of reasons surrounding why an individual child or adolescent experienced a prolonged stay in a hospital emergency room.

Sixth, Mr. Morgan concurred with the working paper that more "specialty" programs for children and adolescents need to be developed, and pointed out that MHA has been working with the Commission, the Health Services Cost Review Commission, and private providers to develop such programs. Recently, for example, MHA and Sheppard Pratt Health Systems have been working in a cooperative effort to develop a program for dually diagnosed (mentally ill/developmentally disabled) adolescents.

Finally, Mr. Morgan sought to clarify that "the 'Lisa L' lawsuit was settled without any admission of liability" by the State, and requested, accordingly, that the passage in the working

paper read as follows: "children and adolescent patients allegedly over-stayed in State and private psychiatric hospitals, and were allegedly not receiving appropriate care."

Writing on behalf of **The Governor's Office for Children, Youth, and Families ("OCYF")**, its Director for Policy and Planning, Patricia Spann, expressed support for Option 1 in the working paper. Specifically, Ms. Spann notes that the OCYF believes that the Subcabinet for Children, Youth, and Families[2] should play a significant role in assisting the MHCC in determining child and adolescent inpatient psychiatric and RTC bed need. Ms. Spann points out that the working paper recognizes that as the Subcabinet has the responsibility for planning, budgeting, and legislation relating to all children and adolescents in the State, it is logical that it have a major part in planning for child and adolescent inpatient psychiatric and RTC services.

Ms. Spann offers the suggestion that the Commission incorporate an addition into Option 1, which is to maintain the existing Certificate of Need review program. That addition would be the requirement that the Subcabinet provide review and comment on any proposed changes to the State Health Plan and "any Commission recommendations regarding changes to Certificates of Need issued or exemptions granted" for child and adolescent psychiatric or RTC services. Ms. Spann points out that there is already a standing interagency committee of the Subcabinet Partnership Team, the Resource Development and Licensing Committee, that reviews community-based resource needs for children as well as adolescents, the continuum of care ranging from RTC bed need to community group home placements. Moreover, Ms. Spann notes that it would be consistent with the committee's existing responsibilities that it analyze and comment on recommendations to the Subcabinet relating to RTC bed need, since all Subcabinet agencies have representatives on this committee.

III. Staff Analysis of Public Comments

In its examination of the public response to this working paper, Commission Staff notes that all of the respondents supported Option 1: Maintain Existing Certificate of Need Review Program Regulation for Child and Adolescent Inpatient Psychiatric Beds and RTC Beds, with Commission-Mandated Data Collection for RTC Beds. Three of the four respondents (Villa Maria, Woodbourne, Maryland Disability Law Center) stated specifically that the Commission was the entity best qualified to plan for the comprehensive mental health needs of children and adolescents who require inpatient or residential treatment center care. However, respondents could not agree which entity should be responsible and accountable for collecting, aggregating, and analyzing RTC data.

Additionally, Villa Maria and Woodbourne supported Option 2: To Expand Certificate of Need Program Regulation and Option 3 B.: Deregulate from Certificate of Need Review

[2] Created to promote interagency collaboration and increased partnership opportunities across the State in issues focused on children and their families, the Subcabinet provides leadership and policy direction, and is comprised of the Secretaries of the Departments of Budget and Management, Health and Mental Hygiene, Human Resources, Juvenile Justice, the State Superintendent of Schools, the Special Secretary for Children, Youth, and Families, the Director of the Office for Individuals with Disabilities, and representatives from other State agencies as designated by the Governor. The Subcabinet Partnership Team addresses day-to-day operations, and makes policy recommendations to the Subcabinet.
(Source: www.ocyf.state.md.us)

Child/Adolescent Hospital Facilities and Maintain Regulation and Planning for RTCs With the Commission. Neither Mr. Greenberg, for Villa Maria, nor Dr.Weinstein, for Woodbourne, provided a detailed explanation of how they would want to see the CON program expanded for child and adolescent psychiatric services, or how support for expanding CON was compatible with deregulation of inpatient child and adolescent bed capacity and facilities.

It remains unclear why both Mr. Greenberg and Dr. Weinstein supported Option 3B along with Option 1 as these two options would appear to rule out one another. Option 1 calls for maintaining the current CON review program *in toto* for child and adolescent inpatient psychiatric beds as well as RTC beds, with Commission-mandated data collection for RTC beds. However, Option 3B calls for the deregulation from Certificate of Need review of child and adolescent hospital facilities and maintaining regulation and planning for RTCs with the Commission. Option 3B only maintains CON for RTCs and does not address the full continuum of care that would be in place in Options 1 and 2. Supporting Option 3B is a more piece-meal approach to planning child and adolescent mental health services because this option does not take into account the impact of hospital–based inpatient mental health services upon the RTC and less intrusive community-based services mentioned as part of the desirable full continuum of care in the comments from Villa Maria and Woodbourne[3].

Mr. Morgan, for MHA, takes issue with the working paper's assertion of Maryland Health Partners' "increasingly restrictive utilization decisions." In order to focus on child and adolescent utilization trends by age and year for discharges, patient days, total charges, average length of stay, average charge, and per diem for acute general and private psychiatric hospitals, Commission Staff relied upon supporting data from the Maryland Hospital Discharge Abstract, CY 1996-CY 2000 [for general and private hospital data], and Maryland Health Management Information System, CY 1996 CY 2000 [for State psychiatric hospital data] as noted in Appendices I-X.

To more precisely focus on what occurred in the State from 1998, when the Maryland's Public Mental Health System went from a grant-based system to a fee-for-service system, Staff reviewed the years 1998-2000[4]. That review revealed that, from calendar year 1998 to calendar year 2000, discharges in all Maryland inpatient settings for children decreased from 1,431 to 1,369, discharges for adolescents went from 4,288 to 3,876. Additionally, combined average length of stay for children went from 12.82 in 1998 to 11.55 in 2000, a drop of 9.9 percent; for adolescents the combined average length of stay went from 12.58 in 1998 to 8.70 in 2000, a 30.3 percent drop. For the period of 1998-2000, the combined child and adolescent population had a drop of 25.3 percent in the average length of stay from 12.64 days in 1998 to 9.44 days in 2000.

[3] It could be argued that if the State had planned for a fuller continuum of services, including hospital-based care, that the problems associated with children getting 'stuck' and then overstaying in state and private psychiatric hospitals, precipitating the "Lisa L" lawsuit, might have been avoided. The State's community access planning efforts to serve persons with all disabilities in the most integrated community-based settings, and therefore carry out the principles of the Supreme Court's decision in *Olmstead v. L.C., 527 U.S. 581(1999)* are consistent with Options 1 and 2, but inconsistent with Option 3B.

[4] CY 2000 represents the latest full-year data available.

During the years 1998-2000, total charges, excluding charges in State psychiatric hospitals[5], to treat mentally ill children decreased from $13, 808,159 in 1998 to $12, 216,300, a decrease of 11.5 percent; and for adolescents total charges decreased 32.7 percent from $31,557,131 in 1998 to $21,238,476 in the year 2000. Combined total charges for these two age cohorts were $45,365,290 in 1998 and $33,454,776 in 2000, a decrease in charges of 26.3 percent. The data show a decrease in utilization and costs across the board for inpatient hospital treatment of children and adolescents.

Mr. Morgan states that "[i]n 1997, there were approximately 9,000 gray zone individuals receiving mental health services. Today, there are more than 17,000 individuals receiving services. Yet the increase in hospital bed occupancy has not increased a similar percentage." However, Mr. Morgan does not specify how many of these individuals are either children or adolescents. Staff's review of MHA's *Draft Document HealthChoice Evaluation – Public Mental Health System, September 2001*, page 18, notes that 15,507 gray zone individuals were noted as receiving services based on claims data through June 30, 2001 (the end of State fiscal year 2001). Commission Staff believes that this figure represents the total gray zone population[6], and not just the child and adolescent gray zone population. Furthermore, the restricted utilization by the child and adolescent gray zone population that the working paper discussed is a recent development which MHA would not be fully able to analyze until six months after the end of the State fiscal year, by which time all claims from providers are required to be submitted. The Commission, which does not have full access to this data, must rely on providers' anecdotal reports and the hospital discharge abstract data.

In the process of preparing this working paper, Staff encountered problems in obtaining relevant, current RTC data from the ASO. Mr. Morgan has made clear that the ASO, Maryland Health Partners, is a contractor of MHA. It cannot release information to private or public agencies without the approval of MHA. He goes on to note that MHA and the Health Services & Evaluation Administration have an agreement that all data regarding the HealthChoice system must go through a review process before it may release the data to another entity. This process ensures that MHA has a clear understanding of how the information will be utilized, and to ensure the integrity of the data. However, staff's experience with data requests has been less than satisfactory, yielding less information than is needed or none at all.[7]

With regard to available data, Mr. Morgan agrees that the working paper is correct in noting that the Public Mental Health System is limited to information regarding only those persons and services that it funds. However, he observes that MHA has a relationship with the

[5] This data was not available.

[6] The latest data from MHA, including all age groups, indicate that, in State fiscal year 2000, 72 out of a total of 20,036 gray zone individuals received inpatient psychiatric care. In State fiscal year 1998, the data show that 57 out of a total of 13,521 gray zone individuals received inpatient psychiatric care. (Source: *Draft Document HealthChoice Evaluation – Public Mental Health System*, September 2001, page 53)

[7] In the development of this paper, MHCC staff in November 2001 requested any and all data that MHA had on RTCs from Maryland Health Partners, and received one chart that is found on Page 67 in Appendix XI in the Working Paper. During its recent review of the proposed relocation of the 17 RTC beds from Rose Hill to Sheppard-Pratt, MHCC staff requested patient origin data three weeks before the Rose Hill decision for data, and received no response.

RTC Coalition[8], and has been able to get information that provides a "complete picture" of RTC utilization; although, he recognizes the need for a truly comprehensive data bank and bed registry for RTCs, which would also include information on what types of beds are available on any one day, and thus permit easier access by providers. Such a comprehensive data bank is critically needed by the Commission to answer the questions that arise during the course of its planning efforts and CON decisions related to Maryland's mental health services, but there is no data collection system in place for child and adolescent RTCs on which the Commission can rely.

The final point raised by Mr. Morgan in regard to the 'Lisa L' lawsuit-that the suit was settled without any admission of liability, is correct. Since the settlement precluded a definitive finding in this case, the final text of the working paper will incorporate the fact that allegations of inappropriate care and lengths of stay were addressed by the Department of Health and Mental Hygiene.

In her comments, for OCYF, Ms. Spann has suggested that the addition of a requirement to Option 1 such that the Subcabinet provide input in matters relating to child and adolescent inpatient psychiatric and RTC CON issues that come before the Commission.

This is an already established practice of the staff in these matters[9], particularly with respect to RTC issues, although obtaining a timely and representative response has sometimes proven difficult. While this is expected of such a broad-based coordinating entity, representing agencies with complex policy issues and daunting resource needs, the Commission's CON decision-making process is time-limited. However, while the opportunities to affect and inform a CON decision require a fairly rapid response, good planning needs ongoing discussion and intensive database development, and that need is both pressing and continual. It is that collaboration that Staff believes needs fostering, and a partnership with OCYF and those efforts are welcomed. Staff will include the Subcabinets's Resource and Development and Licensing Committee as a logical point of contact in the Commission's planning work, as it has the child serving agencies that sit as the Subcabinet for Children, Youth, and Families.

IV. Staff Recommendation

Based on both the research and analysis performed in the preparation of this working paper and on public comment received on that document, Staff proposes that the Commission consider the following three recommendations to the General Assembly, on the future of Certificate of Need regulation of child and adolescent inpatient psychiatric services and RTC services in Maryland:

1. The Commission should continue its regulatory oversight of child and adolescent inpatient psychiatric and residential treatment center ("RTC") services through the Certificate of Need review process.

[8] The RTC Coalition is an *ad hoc* coalition that states that it represents all RTCs in Maryland.

[9] A Memorandum of Understanding, signed by all members of the Subcabinet and the Maryland Health Resources Planning Commission in May 1995, remains in effect to help assure the development of a balanced continuum of care through joint review and comment on specific Certificate of Need proposals.

Staff reiterates its first recommendation that the Commission continue to regulate the establishment of child and adolescent psychiatric and RTC beds and facilities by means of the Certificate of Need process.

2. The Commission should modify the State Health Plan's current requirement for a separate Certificate of Need for each additional category of inpatient psychiatric service, to require an exemption from CON. Specific standards should be established in the State Health Plan for each category of inpatient psychiatric service.

Staff recommends a change to the present State Health Plan's requirement that a general hospital with an existing inpatient service obtain an additional separate CON approval for each category of psychiatric care. Staff will develop specific State Health Plan standards to guide the review and approval of the proposed additional service, which will be included in the update and revision of the Plan, and thereby receive extensive additional public comments as part of the regulatory review process. These would include consideration of requirements for Board Eligible/Board Certified specialists in the service to be added, specialized staffing, and separate clinical space and programs.

3. The Commission should support efforts to establish an on-going comprehensive data system and bed registry for RTCs. The Commission, in partnership with the Governor's Office of Children, Youth, and Families and the Mental Hygiene Administration, should make recommendations to conduct a study on the scope, content, and on-going operation of this database.

It is critical that, for purposes of effective planning and sound CON decisions for RTC services, there be a comprehensive data bank and bed registry in place. To realize the development of such a data system, will require adequate resources and agreements among key stakeholders on the appropriate roles of each agency.

APPENDIX 1

Public Comments